DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue, Suite 85, Sacramento CA 95825-3241
Telephone: (916) 263-2300 Fax: (916) 263-2140

APPLICANT'S DECLARATION REGARDING SPECIAL PERMIT

Business & Professions Code §1640

❑ Initial permit

❑ Renewal of permit

Name _____

THIS IS TO CERTIFY that I have read the provisions of Business & Professions Code Article 2.5, Chapter 4, Division 2, §§ 1640, 1641, and 1642; that I understand and acknowledge that when my full-time employment is terminated at (name of dental school)_____, or when I am employed less than full-time by said dental school, the Special Permit will be automatically revoked. In accordance with the provisions of § 1642(a), I will voluntarily surrender the permit to the Board and will no longer be eligible to practice unless I hold a California dental license.

I also understand that the Special Permit authorizes practice only in my specialty area and only at the University or its affiliated institutions as approved by the Board.

I DECLARE under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

EXECUTED at _____ , CA on this ____ day of_____, 20_____.

_____
Signature of Applicant

_____
Daytime telephone number

State of California Department of Consumer Affairs

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DECLARATION OF THE DEAN FOR SPECIAL PERMIT

Business & Professions Code §1640

❑ Initial permit

❑ Renewal of permit

Name of applicant _____

To The Dental Board of California:

I, _____ , DO HEREBY CERTIFY that I am the Dean of the

School of Dentistry, _____,

located at this address _____.

In such official capacity, I certify that the following information in support of the above-named Special Permit applicant to practice dentistry pursuant to the provisions of Business & Professions Code Article 2.5, Chapter 4, Division 2, §§ 1640, 1641, and 1642 is true and correct.

Said applicant has a current contract of employment with the above-name dental school: (check one)

___ Full Time Professor ___ Full Time Associate Professor ___ Full Time Assistant Professor

Note: Full time employment means a minimum of four days per week

Current contract dates:_____ through _____.

The dental practice of the applicant is limited to the ADA recognized specialty of

_____, and is limited to the location above or any affiliated institutions which have been approved by the Board.

I have discussed the terms of his/her employment contract with the applicant, who understands and acknowledges that one of the conditions of his/her employment contract is that when his/her full-time employment is terminated at this dental school, his/her Special Permit will be automatically revoked and that he/she will no longer be eligible to practice unless he/she has a California dental license.

Applicant's academic and dental practice schedule is attached.

I DECLARE under the penalty of perjury, under the laws of the State of California that the foregoing is true and correct.

EXECUTED at _____ , CA on this ____ day of_____, 20_____.

_____
Signature of Dean

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SPECIAL PERMIT APPLICANT'S SCHEDULE

❑ Initial permit

❑ Renewal of permit

Name of Applicant_____

Special Permit Number (if renewal) _____

NORMAL WEEKLY SCHEDULE

Complete the following work schedule designating whether at the school or its affiliated facility.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00					
10:00					
11:00					
12:00					
1:00pm					
2:00					
3:00					
4:00					
5:00					
6:00					

Indicate whether:

Research Time	RT
Clinical Time	CT
Administrative Time	AT
Teaching Time	TT
Lunch	L
Private Practice	PP
Other (Explain)	O